May 2002

Fact Sheet:

Fiscal Operations

Within the Program Operations Division, the Fiscal Management and Accountability Branch (FMAB) supports the Department by accounting for and reporting on the funds that counties and providers claim for Drug Medi-Cal (DMC) and Negotiated Net Amount (NNA) contract services. Specifically, FMAB:

- processes and reconciles DMC claims and reports, processes and approves interim payment claims, and processes individual beneficiary claims for minor consent, CalWORKs, and EPSDT services;
- maintains a DMC Payor's List and Master Provider File allowing DMC reimbursements to be made to specific providers and other publicly funded treatment programs to be identified in the State's service delivery system;
- reconciles year-end cost reports for county NNA contracts, county combined NNA and DMC contracts, and direct provider contracts; and
- computes and sets annual reimbursement rates for DMC services.

The primary activities in the two sections of FMAB are processing year-end cost reports and DMC claims.

Processing Year-End Cost Reports

Counties and direct contract providers are required to submit an annual year-end cost report, which identifies actual expenditures of funds allocated by the Department. For the fiscal year ending on June 30, cost reports are due to the Department November 1 of that same calendar year. Staff in FMAB process and reconcile those annual year-end cost reports. In doing so, instructions for completing cost reports are written and distributed to counties and direct contract providers; training and technical assistance are also provided to counties and direct contract providers; problems are researched and resolved; and recommendations for interim settlements and payments are made. The interim settlement is the settlement of actual allowable costs or expenditures as reported in the year-end cost report for alcohol and drug services and perinatal services, if applicable.

DMC Claims

The DMC claims process provides the payment mechanism for federal and state funds dedicated to the DMC Program. When certified, DMC providers provide DMC services to eligible Medi-Cal beneficiaries, those services may be billed for and reimbursed to the provider. Staff in FMAB review and process hard copy, magnetic tape, diskette, and/or electronic claims from counties and providers. The process includes reconciling the results of claims that are approved, denied, on error correction, suspended, and other reports resulting from the initial claims. FMAB staff also provides technical assistance to counties and providers in submitting their claims and process recoupment for services not in compliance with DMC requirements.

DMC claims are tracked by: specific treatment modalities, individual providers, units of service billed and approved for payments, and regular or perinatal program services.

To facilitate cash flow for the provision of alcohol and other drug treatment services to Medi-Cal beneficiaries, counties and direct providers may request and subsequently receive interim payments of State General Funds for DMC services based on approved contract amounts and approved services. FMAB staff coordinates the processing of interim payments and ensures that funds are available in the contractor's agreements before payments are approved for release.

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